

Hospital Statement of Cost

Illinois Department of Public Aid, Office of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

PRELIMINARY

Name of Hospital: Gibson Area Hospital		Medicare Provider Number: 14-1317	
Street: 1120 N. Melvin Street		Public Aid Provider Number: 7006	
City: Gibson City	State: Illinois	Zip: 60936	
Period Covered by Statement:	From: 10-01-05	To: 09-30-06	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) Association	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify)

Type of Hospital

<input checked="" type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify)

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

<input checked="" type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I	<input type="checkbox"/> Medicaid Sub III	<input type="checkbox"/> U of I - Division of Specialized Care for Children

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Gibson Area Hospital 7006 for the cost report beginning 10-01-05 and ending 09-30-06 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

Signed (Officer or Administrator of Provider(s)):

 Name (Typewritten)
 Title _____ Date _____
 Firm _____
 Telephone Number _____

 Name (Typewritten)
 Title _____
 Date _____
 Telephone Number _____

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Public Aid Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 14-1317	Public Aid Provider Number: 7006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-05 To: 09-30-06

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn	Number Of Renal Dialysis Treatments
Part I-Hospital		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics	23	8,395		2,578	30.71%		871	3.00	
2.										
3.										
4.										
5.	Intensive Care Unit	2	730		34	4.66%				
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	2	730		214	29.32%				
16.	Total	27	9,855		2,826	28.68%		871	3.00	
17.	Observation Bed Days				429					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				252			121	2.08	
2.										
3.										
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				45					
16.	Total				297	10.51%		121	2.08	

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Other	Total Hospital
1.	Organized Clinic			
2.	Emergency Room			
3.	Private Referred			
4.	Total Emergency and Private Referred (Sum of Lines 2 and 3)			

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

PRELIMINARY

Medicare Provider Number: 14-1317	Public Aid Provider Number: 7006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-05 To: 09-30-06

Line No.	Ancillary Service Cost Centers	Ratio of Cost to Charges (See Attached Supplement) (1)	Total Billed I/P Charges (Gross) for Health Care Program Patients (2)	Organized O/P Clinic	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2) (5)	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients (3)	Total Billed O/P Charges (Gross) for Health Care Program Patients (4)		O/P Expenses Applicable to Health Care Program (Col. 1 X 3) (6)	O/P Expenses Applicable to Health Care Program (Col. 1 X 4) (7)
1.	Operating Room	0.269066	86,959			23,398		
2.	Recovery Room	0.484553	13,018			6,308		
3.	Delivery and Labor Room	0.857386	85,685			73,465		
4.	Anesthesiology	0.630249	10,200			6,429		
5.	Radiology - Diagnostic	0.338758	49,762			16,857		
6.	Radiology - Therapeutic							
7.	Radioisotope	0.430352	4,520			1,945		
8.	Laboratory	0.296411	41,664			12,350		
9.	Blood							
10.	Blood - Administration	1.017354	1,317			1,340		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.318094	34,683			11,032		
13.	Physical Therapy	1.269194	518			657		
14.	Occupational Therapy	0.641904						
15.	Speech Pathology	1.221425						
16.	EKG	0.057870	2,098			121		
17.	EEG							
18.	Med. / Surg. Supplies	0.342428	39,250			13,440		
19.	Drugs Charged to Patients	0.274488	130,726			35,883		
20.	Renal Dialysis							
21.	Ambulance	1.004514						
22.	Wound Care Center	2.147166						
23.	Sleep Lab	0.400054						
23.01								
23.02								
23.03								
23.04								
23.05								
23.06								
23.07								
23.08								
23.09								
Outpatient Service Cost Centers								
24.	Clinic	2.120018						
25.	Emergency	0.849261	1,958			1,663		
26.	Observation Beds (Non-distinct Par	0.528335						
27.	Total		502,358			204,888		

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to HCFA 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

Medicare Provider Number: 14-1317	Public Aid Provider Number: 7006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-05 To: 09-30-06

Program Inpatient Operating Cost Before Capital Related and Medical Education Cost Adjustments

Line No.	Description	Adults and Pediatrics	Sub I	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 991.29	\$	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	252			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 249,805	\$	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$	\$	\$	\$
5.	Medically necessary private room days applicable to the program (OHF Page 2, Pt. II, Col. 3)				
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)	\$	\$	\$	\$
7.	Total program inpatient routine service cost (Line 3 + Line 6)	\$ 249,805	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 3,054.26		\$
9.	Coronary Care Unit	\$		\$
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 828.70	45	\$ 37,292
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 204,888
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 491,985

**Hospital Statement of Cost
Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program
PRELIMINARY**

Medicare Provider Number: 14-1317	Public Aid Provider Number: 7006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-05 To: 09-30-06

Line No.	Hospital Inpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Inpatient Days (OHF Page 2, Part I, Col. 4)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (OHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.							
4.							
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.							
9.							
10.							
10.01							
10.02							
10.03							
10.04							
10.05							
11.	Nursery						
12.	Subtotal Inpatient Care Svcs. (Lines 2 through 11)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Dept. Charges (HCFA 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges			Program Expenses (Col. 4 X Cols. 5A-C)		
						I / P	Org. Clinic	Ref. O / P	I / P	Org. Clinic	Ref. O / P
						(5A)	(5B)	(5C)	(6A)	(6B)	(6C)
13.	Clinic										
14.	Emergency										
15.	Observation Beds (Non-distinct F										
16.	Subtotal Outpatient Care Svcs. (Lines 13 through 15)										
17.	Total (Sum of Lines 12 and 16)										

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number: 14-1317	Public Aid Provider Number: 7006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-05 To: 09-30-06

Line No.	Cost Centers	Professional Component (HCFA 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (HCFA 2552, W/S C, Pt. 1, Per Dept.)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (OHF Page 3, Col. 2)	Outpatient Program Charges (OHF Page 3, Col. 3 & Col. 4)		Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for Hospital Based Physicians (Col. 3 X Col. 5)	
						Org. Clinic	Ref. O / P		Org. Clinic	Ref. O / P
Inpatient Ancillary Cost Centers		(1)	(2)	(3)	(4)	(5)		(6)	(7)	
1.	Operating Room									
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Radioisotope									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Wound Care Center									
23.	Sleep Lab									
23.01										
23.02										
23.03										
23.04										
23.05										
23.06										
23.07										
23.08										
23.09										
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency									
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.										
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	Total									

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

**Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges**

PRELIMINARY

Medicare Provider Number: 14-1317	Public Aid Provider Number: 7006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-05 To: 09-30-06

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Ancillary Services (OHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (OHF Page 4, Line 18)	491,985		
3.	Interns and Residents Not in an Approved Teaching Program (OHF Page 5, Line 17, Col. 6)			
4.	Hospital Based Physician Services (OHF Page 6, Line 37, Cols. 6 & 7)			
5.	Services of Teaching Physicians (OHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)	491,985		
7.	Ratio of Inpatient, Organized Clinic and Referred O / P Cost to Total Cost (Line 6 Divided by Sum of Line 6, Cols. 1,2, and 3)	100.00%		

Line No.	Customary Charges	Program Inpatient and Outpatient
8.	Ancillary Services (See Instructions)	502,358
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	337,695
	B.	
	C.	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	37,738
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	877,791
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	385,806
13.	Excess of Reasonable Cost Over Customary Charges (Line 6, Sum of Cols. 1 through 3, Minus Line 11)	
14.	Excess Reasonable Cost Applicable to Inpatient, Org. Clinic and Referred Outpatient (Line 7, Each Column X Line 13)	

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number: 14-1317	Public Aid Provider Number: 7006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-05 To: 09-30-06

Line No.	Allowable Cost	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Total Reasonable Cost of Covered Services (OHF Page 7, Line 6, Cols. 1, 2, & 3)	491,985		
2.	Excess Reasonable Cost (OHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	491,985		
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (OHF Page 9, Part III, Line 4, Cols. 2B, 3B, & 4B)			
5.	Protested Amounts (Nonallowable Cost Items) In Accordance With HCFA Pub. 15-II, Sec. 115.2 (B)			
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	491,985		

Line No.	Total Amount Received / Receivable	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
7.	Amount Received / Receivable From:			
	A. State Agency			
	B. Other (Patients and Third Party Payors)			
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)			
9.	Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)			

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-1317	Public Aid Provider Number: 7006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-05 To: 09-30-06

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (OHF Page 7, Line 12)	385,806
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period	Sum of Columns 1 - 4
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (OHF Page 7, Line 13)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2)	Inpatient		Organized Clinic		Referred O / P	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)	Ratio	Amount (Col. 1x4A)
			(1)	(2A)	(2B)	(3A)	(3B)	(4A)
1.	Cost Report Period ended							
2.	Cost Report Period ended							
3.	Cost Report Period ended							
4.	Total (Sum of Lines 1 - 3)							

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-1317	Public Aid Provider Number: 7006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-05 To: 09-30-06

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1. Physicians on hospital staff average per diem (HCFA 2552, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (HCFA 2552, Supplemental W/S D-9, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I	Sub II	Sub III
4. Program inpatient days (OHF Page 2, Part II, Column 4)				
5. Program organized clinic occasions of service (OHF Page 2, Part III, Line 1)				
6. Program referred outpatient occasions of service (OHF page 2, Part III, Line 3)				

Part C. Program Cost

	General Service	Sub I	Sub II	Sub III
7. Program inpatient cost (Line 4 X Line 3) (to OHF Page 7, Col. 1, Line 5)				
8. Program organized clinic cost (Line 5 X Line 3) (to OHF Page 7, Col. 2, Line 5)				
9. Program referred outpatient cost (Line 6 X Line 3) (to OHF Page 7, Col. 3, Line 5)				

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I	Sub II	Sub III
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (HCFA 2552, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)				
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To OHF Page 4, Line 4) ((Line 5 X (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 31.01, or 31.02 Less W/S D-1, Part I, Line 26) Divided by (Line 1A Above))				
7. Private room cost differential adjustment (Line 2B X Line 6)				
8. General inpatient routine service cost (net of swing bed and private room) (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 31.01, or 31.02 Less W/S D-1, Part 1, Line 26, Less Line 7 Above)				
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to OHF Page 4, Line 1)				

**Hospital Statement of Cost
Graduate Medical Education Cost Adjustment Sheet**

OHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 14-1317	Public Aid Provider Number: 7006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-05 To: 09-30-06

Computation of Cost Converters to Include Interns and Residents Cost Adjustment

Line No.	Cost Centers	Total Dept. Costs W/S B, Pt.1 Col. 25	Total Dept. Charges W/S C, Pt. 1	Adjusted Dept. Cost/ Charge Ratio (Transfer to OHF pgs. 3-4)
Inpatient Ancillary Centers				
1.	Operating Room	1,279,377	4,754,875	0.269066
2.	Recovery Room	451,418	931,617	0.484553
3.	Delivery and Labor Room	463,026	540,044	0.857386
4.	Anesthesiology	42,008	66,653	0.630249
5.	Radiology - Diagnostic	3,059,882	9,032,645	0.338758
6.	Radiology - Therapeutic			
7.	Radioisotope	415,692	965,935	0.430352
8.	Laboratory	1,588,228	5,358,199	0.296411
9.	Blood			
10.	Blood - Administration	98,778	97,093	1.017354
11.	Intravenous Therapy			
12.	Respiratory Therapy	430,526	1,353,455	0.318094
13.	Physical Therapy	1,040,971	820,183	1.269194
14.	Occupational Therapy	153,743	239,511	0.641904
15.	Speech Pathology	95,695	78,347	1.221425
16.	EKG	23,745	410,317	0.057870
17.	EEG			
18.	Med. / Surg. Supplies	503,416	1,470,137	0.342428
19.	Drugs Charged to Patients	1,390,144	5,064,507	0.274488
20.	Renal Dialysis			
21.	Ambulance	1,620,211	1,612,930	1.004514
22.	Wound Care Center	218,603	101,810	2.147166
23.	Sleep Lab	130,624	326,516	0.400054
23.01				
23.02				
23.03				
23.04				
23.05				
23.06				
23.07				
23.08				
23.09				
Outpatient Ancillary Centers				
24.	Clinic	337,844	159,359	2.120018
25.	Emergency	2,054,655	2,419,345	0.849261
26.	Observation Beds (Non-distinct Part)	425,263	804,911	0.528335
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	2,980,799	3,007	991.29
28.				
29.				
30.				
31.	Intensive Care Unit	103,845	34	3,054.26
32.	Coronary Care Unit			
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	177,341	214	828.70

**Hospital Statement of Cost
Reconciliation of Patient Days and Revenue**

PRELIMINARY

Medicare Provider Number: 14-1317	Public Aid Provider Number: 7006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-05 To: 09-30-06

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	252		252
Newborn Days	45		45
Total Inpatient Revenue	877,791		877,791
Ancillary Revenue	502,358		502,358
Routine Revenue	375,433		375,433
Inpatient Received and Receivable			
Organized Outpatient Clinic Reconciliation			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
Referred Outpatient and ER Reconciliation			
Referred Outpatient Visits			
Total Referred Outpatient Revenue			
Referred Outpatient Received and Receivable			

Notes:

Filed OHF Supplement No. 2 charges match the filed W/S C charges, except ER.

Adjusted Total Dept. Charges for Emergency Room to match W/S C, Pt. 1, Col. 8.